Cot-death

COT DEATHS LINKED TO VACCINATIONS

by Dr Viera Scheibner, Ph.D (Principal Research Scientist, Retired) & Leif Karlsson. 1991

Although vaccination is undoubtedly the single biggest and most preventable cause of cot-death, it is not the only one. If we write too much about vaccination, we would inevitably create an impression that we think vaccines are the only cause of cot death. The key words in cot death are Non-Specific Stress Syndrome. This is the underlying mechanism of all cot deaths and it explains all pathological and clinical observations.

Cot Death is the single biggest cause of death in infants from about four weeks to six months of age, with another peak at about 9 months in industrially developed countries. It gets a lot of media exposure and people are successfully asked to dip into their pockets and contribute to cot death research. This has been going on for some twenty years now and yet cot death remains a "mystery which may never be resolved".

Perhaps the time has come for the doctors and the public to start asking some relevant questions, such as why, with so much money poured into research, cot death is still officially presented as that famous 'mystery' and more and more money is 'needed' to resolve it in 'years to come'.

COTWATCH: THE FIRST TRUE INFANT BREATHING MONITOR

Some 4.5 years ago, my husband Leif Karlsson, a biomedical engineer specialising in patient monitoring Systems, and myself, a retired Principal Research Scientist, were looking for a paediatrician willing to undertake proper research with our Cotwatch Breathing Monitor. The emphasis with this equipment is on 'breathing' because most, if not all of the machines used to monitor babies' breathing in their homes are not

breathing monitors - they are "motion monitors" where any movement is taken as breathing. After one particular meeting, where our demonstration of marked differences between the level of alarms in near miss and new born babies fell on the deaf ears of cot death 'researchers', we looked at each other and said with one breath: "Let's do a damn good job of this research ourselves".

Leif spent one and a half years developing a microprocessor-based Cotwatch. With this equipment you don't have to rely on records of alarms; you get computer printouts of the longitudinal record of a baby's breathing. You can't have more objective information than that.

STRESS INDUCED BREATHING PATTERNS DISCOVERED BY COTWATCH

Our records confirmed the existence of a Stress-Induced Breathing Pattern, which is a low-volume breathing (5-10% of the volume of normal unstressed breathing), occurring in clusters (3-6 shorter episodes within 10-15 minutes) when a child is incubating illness or teething or following "insults", such as exposure to cigarette smoke, fatigue, over handling by visitors, or vaccination needles. Numerous causes, but the same reaction. Many years ago, a Canadian medical doctor, Dr Hans Selye, became particularly interested in the well-known fact that for a number of days before patients develop symptoms of specific illness, which can be diagnosed, they always show signs of a non-specific nature which are common to many or possibly all diseases. When he in-injected extracts of tissues, or a great variety of noxious substances into rats, he observed the following signs of organ damage: spot-like bleeding into lungs and thymus, shrunken thymus and all lymphatic structures, enlarged adrenal cortex, ulceration of the gastro-intestinal tract, derangements in body creased or control, viscosity of the blood, disappearance of eosinophils (white blood cells) from blood, etc.

He concluded that he was looking at a universal reaction of organisms to any noxious substance. He also connected the results of his experiments with his earlier observations of patients with non-specific symptoms of the initial stages of any illness.

Seyle also concluded that the Non-Specific Stress (or General Adaptation) Syndrome has three stages: the alarm stage when the body is under acute attack and mobilises all its defences; the stage of adaptation or resistance, when it seems to relax and seemingly accepts the intruding noxious substance; and the stage of exhaustion, when the body again tries to rid itself of the intruder. Death may occur in any of the three stages.

FOREWARNING OF COT DEATH OVERLOOKED

What does all this have to do with cot death and breathing?

Similarly to what Dr Selye found with noxious substances, there are many interesting and consistent tell-tale signs that forewarn of impending cot death.

The definition of Cot Death is: "The sudden death of any infant or a young child, which is unexpected by history, and in which a thorough port-mortem examination fails to demonstrate an adequate cause of death". (Byard,1991)

Cot death is a very well-defined pathological entity and all babies who succumb to it have the same post mortem findings. These are: petechiated lungs, thymus and sometimes also pericardium (spot like haemorrhaging on surface); shrunken thymus and lymphatic structures; signs of increased adreno-cortical activity; signs of ulceration of the gastro-intestinal tract (reflux); many babies have low viscosity blood; up to 90% of babies who succumb to cot death have a number of non-specific symptoms for up to three weeks before death, such as runny nose, coated tongue, sticky eyes, otitis media, enlarged tonsils, spleen and liver, rash, a variety of upper respiratory tract infections, and loss of body weight to rnention just a few.

These are all symptoms of the Non-Specific Stress Syndrome as defined by Dr Selye.. Those people involved in Cot Death management all over the world know about these symptoms, but they usually play them down as unimportant and insufficient to cause death in an infant. None of them has connected these well-known symptoms associated with cot death, with the Non-Specific Stress syndrome. Perhaps for their sake this is just as well, because they would have been unable to prove the validity of this connection in the absence of adequate means to demonstrate it in the infant's breathing pattern.

So where does vaccination come into the problem of Cot Death?

VACCINATION - A MAJOR STRESS

Initially we did not know about the controversy surrounding vaccination. We merely observed that vaccination was the single greatest cause of stress in small babies, as indicated by the standard Cotwatch equipment, and also the single greatest factor preceding cot death in a large number of cases. We concluded that the timing of 80% of the cot deaths occurring between the second and sixth months is due to the cumulative effect of infections, timing of immunisations and some inherent specifics in the baby's early development.

We started yet another search for more information. Soon we discovered a wealth of it in medical journals like The Lancet concerning not only the ineffectiveness of vaccines in preventing children from contracting infectious diseases, but also on adverse effects of various vaccines, including death. Regarding the former aspect, we found numerous reports that vaccinated and non-vaccinated children contract the relevant infectious disease at approximately the same rate, or that vaccinated children are even more susceptible to the infectious diseases.

Inevitably, we began recording breathing patterns of babies after vaccination. The results of these recordings were presented to the 2nd Immunisation Conference, held in Canberra, 27~29th May 1991. We demonstrated that microprocessor records of babies' breathing after DPT (Diphtheria, Pertussis, Tetanus) injections reveal a pattern of flare-ups of Stress-Induced Breathing closely following the dynamics of adreno-cortical activity in an individual under stress and as observed by Dr Selye.

We also demonstrated that flare-ups of Stress-Induced Breathing in babies after administration of the DPT vaccine occur characteristically on certain days even though the amplitude of the flare-ups varies from child to child.

For seventy babies who succumbed to cot death, although babies could die on any day after DPT injection, there were significantly more deaths on the days which closely correlated with flare-ups of Stress-Induced Breathing after DPT injections.

The data on the time interval between the DPT injection and cot death in most of the seventy babies was taken from the published reports which concluded that there was no connection between DPT and cot death. The authors of these papers had little idea what they were looking at or what to look for. Most researchers arbitrarily accept that only deaths within 24 hours of administration of the vaccine can be attributed to the effect of the vaccine. Yet, babies may and do die for up to 25 or more days after vaccination, and still as a direct consequence of the toxic effects of the vaccines.

How do we know this? Because of the observed repetition of the pattern of flare-ups of Stress-Induced

Breathing in a number of babies over a long period of time.

HARMFUL VACCINE INGREDIENTS

What are the vaccines composed of?

Vaccines contain live or 'attenuated' (weakened) viruses and bacteria or parts of them (representing foreign genetic material), animal tissue, formaldehyde and/or aluminium

phosphate or hydroxide. The toxicity of vaccines varies widely and unpredictably, a DPT vaccine containing from 1 to 26.9 micrograms of endotoxin per millilitre. Geraghty and others in California tried unsuccessfully to make sure that the toxicity and composition of the vaccines is properly disclosed on the ampules.

Injecting any of these substances into the blood stream of another animal species, including humans, is absolutely biologically unacceptable. H.L. Coulter in his book, Vaccination, Social Violence and Criminality: the Medical Assault on the American Brain, mentions that repeated injections of sterile extracts of rabbit brain tissue into monkeys cause an 'experimental allergic encephalomyclitis' in the monkeys. Regardless of the validity or otherwise of animal experiments for humans, Coulter points out that it is an observed fact that vaccine injections often cause the same syndrome in human babies. It has been confirmed that a great number of babies, if not all, suffer a clinical or subclinical encephalitis shortly after being injected with a variety of vaccines. Coulter talks about a postencephalitic syndrome.

The great increase in a large array of brain-related conditions in the United States closely followed chronologically mandatory administration of vaccines en masse in that country.

These conditions include autism, learning difficulties, cerebral palsy, dyslexia, hyperactivity, deafness and blindness, left-handedness (according to latest statistics, left-handed people live 9 years less than right-handed people) and permanent brain damage with serious and often life-long consequences.

Vaccines by virtue of their composition act as noxious substances and elicit a response equivalent to the Non-Specific Stress Syndrome.

Recently, we recorded the breathing of an infant injected with only DT (the P component was omitted because the baby had experienced a violent reaction to the two previous DPT injection). The reaction, as reflected in its breathing, closely resembled the record of its breathing after DPT vaccination. This is not meant to justify the inclusion of the Pertussis (Whooping Cough) component, but to emonstrate that all vaccines are potentially harmful.

MANY DOCTORS DO NOT VACCINATE THEIR OWN CHILDREN!

It should worry all of us that a large number of medical doctors are forcefully (by psychological pressure and publicity campaigns) without producing any evidence whatsoever of the benefits of vaccination and against all the evidence of the ineffectiveness and dangers of vaccines, injecting vaccines into our children. There

are even noises indicating that soon the same forceful and unreasonable attitudes will be adopted towards adults.

This is especially bad since it is a public secret that many medical doctors do not vaccinate their own children. This extraordinary fact is reported in DPT-A Shot in The Dark, by H.C. Coulter & B.L. Fisher. These authors also report that most gynaecologists in the USA refused to be injected with Rubella vaccine. Were they afraid of the side-effects, whilst routinely recommending the procedure for women of childbearing age?

Our conclusion is that if vaccination were to be suspended, the cot death rate would be halved!

What are the remainder of cot deaths attributed to?

SUCCESSION OF HARMFUL MEDICAL PROCEDURES

The Non-Specific Stress Syndrome is the key to cot deaths. It is the consistent, general reaction of mammals, including humans, to any damage or injury or to substances perceived as noxious by the recipient's body. There are a great many injuries or substances perceived as noxious which affect babies and produce the same response.

The indiscriminate and routine administration of pain killers during birth, and the substances used for inductions expose our babies to potent allopathic chemicals shortly before they are born. To say that these substances do not affect the babies is not only highly unscientific, it is against commonsense. Before babies have a chance to fully recover from these potent chemicals, they may be given nasal drops and cough mixtures and, and worse still, antibiotics for those first common colds.

Most of these substances are immuno-suppressive and are not helping the child's immune system to be primed and challenged in a natural and beneficial way by the common cold.

Again, before a baby has a chance to fully recover from the effects of these potent chemicals, there is the first DPT injection. So the immature immune system of a baby is further suppressed, allowing micro-organisms to become especially virulent and life-threatening. This leads to further drug administration, a vicious circle, unfortunately too often resulting in cot death.

The official figure of 2 cot deaths per 1,000 babies is twenty years old, and obsolete. The rate is more like 7-10 per 1,000, otherwise we would not even hear about cot death.

Our records demonstrate that there is a direct causal relationship between injections of DPT and cot deaths. The time has come to call for suspension of all vaccination programmes.

This article appeared in Nexus, Oct-Nov 1991.

[Home] [Vaccines]